UnitedHealthcare Community Plan

Sublingual Immunotherapy (SLIT)
Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS:

- **Does the patient have a diagnosis of moderate to severe grass pollen-induced allergic rhinitis? □ Yes □ No**
  If no, list diagnosis: _____

- **Does the patient have a history of failure, contraindication, or intolerance to two of the following:**
  - **□ Oral antihistamine [e.g. cetirizine (Zyrtec)]**
  - **□ Intranasal antihistamine [e.g. azelastine (Astelin)]**
  - **□ Intranasal corticosteroid [e.g. fluticasone (Flonase)]**
  - **□ Leukotriene inhibitor [e.g. montelukast (Singulair)]**

  (If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

- **Does the patient have symptomatic and/or uncontrolled asthma? □ Yes □ No**

- **Is requested medication being prescribed by, or in consultation with, a specialist in allergy and immunology?**
  □ Yes □ No

Requests for GRASTEK:

- **Is the patient's diagnosis confirmed by one of the following:**
  - **□ Positive skin test to Timothy grass or cross-reactive grass pollens (e.g., Sweet Vernal, Orchard/Cocksfoot, Perennial Rye, Kentucky blue/June grass, Meadow Fescue, or Redtop)**
  - **□ *In vitro* testing for pollen-specific IgE antibodies for Timothy grass or cross-reactive grass pollens (e.g., Sweet Vernal, Orchard/Cocksfoot, Perennial Rye, Kentucky blue/June grass, Meadow Fescue, or Redtop)**

- **Has treatment been started, or will be started, at least 12 weeks before the beginning of the grass pollen season?**
  □ Yes □ No

- **Will Grastek be received in combination with similar cross-reactive grass pollen immunotherapy (e.g. Oralair)?**
  □ Yes □ No

Requests for ORALAIR:

- **Is the patient's diagnosis confirmed by one of the following: □ Yes □ No (check which applies)**
  - **□ Positive skin test to any of the five grass species contained in Oralair [(i.e., Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue grass mixed pollens) or cross-reactive grass pollens (e.g., Cocksfoot, Meadow Fescue, or Redtop)]**
  - **□ *In vitro* testing for pollen-specific IgE antibodies for any of the five grass species contained in Oralair [(i.e., Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue grass mixed pollens) or cross-reactive grass pollens (e.g., Cocksfoot, Meadow Fescue, or Redtop)]**

- **Has treatment been started, or will be started, at least 4 months before the beginning of the grass pollen season?**
  □ Yes □ No

Requests for RAGWITEK:

- **Does the patient have a diagnosis of moderate to severe short ragweed pollen-induced allergic rhinitis?**
  □ Yes □ No If no, list diagnosis: _____

- **Is the patient's diagnosis confirmed by one of the following: □ Yes □ No (check which applies)**
  - **□ Positive skin test to short ragweed pollen**
  - **□ *In vitro* testing for pollen-specific IgE antibodies for short ragweed pollen**

- **Has treatment been started, or will be started, at least 12 weeks before the beginning of the short ragweed pollen season? □ Yes □ No**

- **Will Oralair be received in combination with similar cross-reactive grass pollen immunotherapy (e.g. Grastek)?**
  □ Yes □ No

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Requests for ODACTRA:

- **Does the patient have a diagnosis of house dust mite (HDM)-induced allergic rhinitis? □ Yes □ No**
  If no, list diagnosis: _____

- **Is the patient's diagnosis confirmed by one of the following: □ Yes □ No (check which applies)**
  - **□ Positive skin test to licensed house dust mite allergen extracts**
  - **□ *In vitro testing* for IgE antibodies to *Dermatophagoides farinae* or *Dermatophagoides pteronyssinus* house dust mites**

Requests for CONTINUATION OF THERAPY:

- **Does the patient have a documented positive clinical response to therapy? □ Yes □ No**
  If yes, list response: _____

Provider Signature: _____ Date: _____